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May 11, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chronic Pain Management 5/WK X2WKS/ 10 sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
American Board Certified Physician with 16 years' experience in Physical Medicine and Rehabilitation

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
According to the very limited documentation sent for review. This is a female who was injured on xx/xx/xx. The original injury is described as occurring when the injured worker was approached from behind who pulled the injured worker to the floor. According to UR MRI's of both the cervical and lumbar spine were previously completed. MRI revealed post-surgical changes consistent with an L5-S1 fusion with posterior decompression and retained hardware. A significant narrowing of the spinal canal or neuroforaminal are noted. MRI of the cervical spine revealed muscle spasm and broad- based disc protrusions at the C3-4 level with impinges upon the anterior aspect of the thecal sac. Similar disc protrusions were noted C4-5 and C5-6, but the neuroforamen are noted to be patented. Functional capacity evaluation was completed on March 8, 2015 indicated that the injured worker could return to work with some restrictions. Prior conservative care has consisted of physical therapy, chiropractic care, and massage therapy. Work hardening program has not previously been completed. Current medications include naproxen, acetaminophen, and hydrocodone. The clinician indicates that no treatments, including operative or conservative are pending. The injured worker is noted as not currently working and has not worked since the injury date. A low back injury is noted to predate the most recent injury. The clinical

examination noted diminished cervical range of motion. Lumbar and thoracic ranges of motion are within normal limits. Motor and sensory testing of the upper and lower extremities are grossly normal with the exception of diminished right shoulder range of motion. The clinician further goes on to note that condition appears to become static that upper extremities. An impairment rating of 5% is provided. The designated doctor does not make her recommendation for a chronic pain program. The document dated April 2, 2015 indicates that the injured worker has been in a cognitive pain management session since March 25, 2015 and has completed 7 of 10 authorized sessions. The request is for an additional 10 sessions in this chronic pain program. The clinician indicates that the additional sessions are necessary to allow the injured worker to transition to a higher level of functioning. The injured worker has indicated that medication use has been reduced following admissions to the program. No objective examination findings are provided.

04/02/15: Progress Summary. Progress summary reports that patient began attending cognitive pain management sessions on 03/23/15 and has been consistent with her attendance. Patient has completed 7 out of 10 authorized sessions and requests 10 additional sessions. Patient's original date of injury was on xx/xx/xx. Since the original injury patient seems to have been suffering from stress, irritability, anxiety, depression and has since developed chronic pain symptoms and has not been able to return to work. The request for additional sessions is being made in order to continue to strengthen and build on the progress that has made thus far in acquiring effective pain management skills and techniques. The goal is to provide a foundation of knowledge and skills for lifetime adjustment. The patient reports that before entering the program she was taking her medication as prescribed by the doctor; however, after completion of group therapy sessions of the program, the patient reported that she had reduced her medication intake to an as needed basis. The patient has voiced considerable interest in managing her pain without dependency of medication. In Summary continues to progress toward her goals and ability to improve in the daily activities of her life. continues to participate in the written assignments, assigned homework and shares her thoughts with the group members. She is learning adequate coping mechanisms to deal with the multifaceted deficits that are occurring as a response to her injury. The patient demonstrates the need for additional intensive treatment and continued support in order to return to a higher level of function and return to the workforce.

04/10/15: UR. Rational: The ODG supports admission to a chronic pain program. The injured worker notes subjective improvement of pain from a 7-8/10 to 6/10 and reports reduced medication usage. Per the peer conversation, the claimant has completed the seven out of ten sessions already approved. The claimant has had the individual therapy before the program. The plan is to get the claimant back to work upon the completion of the program and believes this is totally achievable. Ten sessions have already been approved. The claimant has yet to attend three of those sessions. Beyond this further physical therapy is not considered medically necessary.

04/15/15: Request for Reconsideration. In summary xx has undergone various forms of treatment. She is currently taking prescribed hydrocodone 7.5mg. Other forms of previous treatment include: x-rays, MRI's Physical therapy, TENs unit, and EMG, however none have seem completely successful in lowering her levels of pain. Thus there is limited evidence of relief and the previous methods have not garnered the desired results. The Patient needs the chronic pain management program to delve into the problems she is experiencing that is limiting her recovery and return to work. depression and anxiety seem to be affected by instability caused by her circumstances regarding her compensation and physical limitation she is placed under due to her work injury

04/20/15: UR. Rational: The ODG supports the use of chronic pain management programs when the criteria are met. Based on the documentation provided, there does not appear to be any clear objective evidence of improved function and no recent physical examination finding or functional capacity evaluation were completed following the initial course of the program. Secondary to insufficient information regarding substantial objective improvement the requested additional chronic pain management program visits are considered not medically necessary and are recommended for non-certification.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Determination: denial of additional 10 sessions of chronic pain management program is UPHELD/AGREED UPON since even though there is notation of subjective improvement in pain, decreased medication use and learned pain coping/relaxation techniques, there is NO OBJECTIVE evidence of improvement after the first 7-10 sessions.

There is no information regarding the number of hours completed, nor the number of hours requested.

VAS pain score is with minimal change, from 7-8/10 to 6/10.
Psychometric testing is notable for minimal change in anxiety with BAI from to 18 to 13 --still mild, and actually increased depression with BDI from 17 to 19 -- still moderate. There is no comparative data for fear avoidance measures.
There is absolutely no data regarding functional abilities -- no lifting, carrying, pushing, pulling, or dynamic activity (such as walking or bending).
There is no documentation of medications, the names, the dosages, the frequency of actual use, and comparative use before the program to current.
There is no documentation of the type of work of the job of injury, the required job demands, the availability of that job, the comparison of current physical and cognitive capabilities versus the required job demands, the goal to return to that job, and if not, specific vocational options that have been explored.

Therefore, the request for Chronic Pain Management 5/WK X2WKS/ 10 sessions is not found to be medically necessary.

PER ODG:

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

(1) The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following: (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.

(3) An adequate and thorough multidisciplinary evaluation has been made. This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.

(4) If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.

(5) If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.

(6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.

(7) There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware that successful treatment may change compensation and/or other secondary gains. In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.
(8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.
(9) If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.
(10) Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.
(11) Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.
(12) Total treatment duration should generally not exceed 4 weeks (20 full-days or 160 hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. (Sanders, 2005) If treatment duration in excess of 4 weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).
(13) At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.
(14) Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.
(15) Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.
Inpatient pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don’t have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive

oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. (Keel, 1998) (Kool, 2005) (Buchner, 2006) (Kool, 2007) As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See Chronic pain programs, opioids; Functional restoration programs.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**